#2

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

454 3/09/14

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445509	A. BUILDING _____ B. WING _____	01/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF OLD HICKORY VILLAGE	1250 ROBINSON ROAD OLD HICKORY, TN 37138

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During the annual Re-Certification survey and investigation of complaints #31500 and #32761 conducted January 7-10, 2014, at Life Care Center of Old Hickory Village, deficiencies were cited in relation to the complaints.	F 000	Life Care Center of Old Hickory Village is committed to upholding the highest standards of care for its residents. This includes substantial compliance with all applicable standards and regulatory requirements. The facility respectfully works in cooperation with the State of Tennessee Department of Health toward the best interest of those who require the services we provide. While this Plan of Correction is not to be considered an admission of validity of any findings, it is submitted in good faith as a required response to the survey conducted January 7-10, 2014. This Plan of Correction is the facility's allegation of substantial compliance with Federal and State requirements.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157	F 157 Resident #170 completed his/her rehabilitation stay and discharged home safely in November 2013 Audit completed by Nursing Managers/Coordinators on other residents with significant weight change (significant defined as greater than 5% change in one month) to ensure notification of change to physician or physician extender, Nurse Practitioner.	2/10/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director 1/31/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to notify the physician of a significant weight increase for one resident (#170) of thirty-five residents reviewed. The findings included: Resident #170 was admitted to the facility on October 4, 2013, with diagnoses including Hypertension, Esophageal Reflux, Morbid Obesity, Arthropathy, Knee Replacement, Lymphedema, Chronic Pain, Depression, Anemia, and Atrial Fibrillation. Medical record review of the Weight History revealed the admission weight on October 4, 2013, was 250 pounds (#). Further review revealed the weight on October 14, 2013, was 255#, a five pound increase in one week. Further review revealed the weight on October 21, 2013, was 258#, an eight pound increase in the two weeks after admission. Further review revealed the weight on October 28, 2013, was 316#, a significant (significant defined as greater than 5% change in one month) increase of 58# in one week or 18.4%. Further review revealed the weight on November 4, 2013, was 319#, a significant increase of 69# or 21.6% in one month. Medical record review of the only two physician progress notes dated October 14, 2013, and October 23, 2013, revealed no documentation of	F 157	F157 (con't) Nurses, RNs and LPNs, educated by Staff Development Coordinator to ensure knowledge of significant weight loss parameters and when to notify physician of significant weight loss. Education provided to physician and physician extenders by Director of Nursing to ensure if notified of significant weight loss it will be noted in physician notes/progress reports. Physician notification will be tracked during weekly Nutrition Intervention Program meeting by Dietician or designee. Dietician or designee will report the results of notification of physician regarding significant weight loss to the Performance Improvement Committee until 3 continuous months of 100% compliance and report any discrepancies to Performance Improvement Committee, consisting of Interdisciplinary Team made up of the Medical Director, Director of Nursing, Executive Director, and other department heads including Social Services Director, Staff Development Coordinator, Executive Chef, Dietician, Recreation Services Director, Director of Rehab, Health Information Management Director, for further recommendations if needed.	2/10/14

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F 157	Continued From page 2 the resident's weight or the changes in the weight. Review of the facility policy entitled Weight Monitoring with the last revised date of March 1, 2013, revealed, "...the criteria for reweighs are as follows: A reweigh is obtained when the resident's weight varies by 5 lbs in a month or 3 lbs in a week...For re-evaluating weight changes: Weight variances are reviewed for residents with a 5% weight change in 30 days...Any resident who experiences...a significant weight change...Notification to the physician...Unplanned weight gain in a resident may have significant health implications and therefore is addressed..." Interview on January 9, 2014, at 11:30 a.m., in the Administrator's office, with the Administrator, Director of Nursing, and the Regional Vice President, confirmed the facility failed to follow their policy to reweigh the resident after a three pound weight change in one week. Further interview confirmed the facility failed to notify the physician per facility policy of the significant weight gain experienced in one week and one month after the admission.	F 157		2/10/14
F 202 SS=D	483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary	F 202	F 202 Resident #226 was discharged safely to psychiatric facility on day of incident. Audit was conducted by Social Services Director and Social Services assistant to ensure care plans and assessments are accurate on any resident with behaviors. No other residents had behaviors that would require being sent to a psychiatric facility.	

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F 202	Continued From page 3 under paragraph (a)(2)(iv) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to document assements and care plans developed to meet a resident's needs before discharging for on resident (#226) of thirty-five residents reviewed. The findings included: Resident #226 was admitted to the facility on September 4, 2013, with diagnoses including Hypertension, Atherosclerotic Cardiovascular Disease, Osteoarthritis, Abdominal Aortic Aneurysm, Evacuation of Subdural Hematoma, Cerebrovascular Accident, Coronary Artery Bypass Graft, and Pacemaker Insertion. Medical record review of a nursing note dated October 23, 2013, revealed, "...Pounding screen of television with a book. Also reached and pulled on television several times, then continued to smear thickened liquids from a cup all over the screen..." Medical record review of a nursing note dated November 4, 2013, revealed, "...resident had a butter knife and was striking out at staff. The resident stated people were trying to take things away from...Resident told spouse on telephone 'you need to call the police and tell them they need to come take care of things. You better listen to me or someone will be hurt.' Physician was called and ordered the resident be sent out for altered mental status and combativeness..."	F 202	F202 (con't) Education was provided to Social Services associates, MDS Nurses, RNs, and LPNs to ensure knowledge of when and how to care plan behaviors. Education included documenting of interventions to prevent/de-escalate behavior as well as if the resident will be admitted to a psychiatric facility. Social Service director will report the results of defiant practice to the Performance Improvement Committee until 3 continuous months of 100% compliance and report any discrepancies to Performance Improvement Committee, consisting of Interdisciplinary Team made up of the Medical Director, Director of Nursing, Executive Director, and other department heads including Social Services Director, Staff Development Coordinator, Executive Chef, Dietician, Recreation Services Director, Director of Rehab, Health Information Management Director, for further recommendations if needed.	2/10/14

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F 202	Continued From page 4 Review of the care plan revealed no documentation of behavior as being a problem and no interventions to prevent/de-escalate behaviors. Interview with the Administrator and Director of Nursing (DON) on January 9, 2014, at 8:45 a.m., in the Administrator's office, revealed the Administrator was called to the dining room where the resident was found with knife, fork, and spoon in hand, waving the arm around. Continued interview revealed the resident dropped the knife on the floor and the Administrator was able to pick it up. Further interview revealed the Administrator refused readmission to the resident after discharge from the psychiatric facility because the facility was unable to care for residents with behavioral issues and the Administrator felt the resident was a risk to himself, staff, and visitors. Interview with the DON confirmed the care plan did not reflect the resident's behavior issues or interventions put in place in an attempt to meet the resident's needs.	F 202		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	F 279 Both residents, #52 and #226, were discharged from facility in September and November 2013 respectively. Audit conducted by Unit Managers/Coordinators and MDS Nurses to ensure other residents on anticoagulant medications have a care plan for monitoring signs/symptoms of potential bleeding. Audit conducted by Social Services Director and MDS Nurses to ensure other residents with known behavior	2/4/14

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F 279	Continued From page 5 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to develop comprehensive care plans for two residents (#52, #226) of thirty-five residents reviewed. The findings included: Resident #52 was admitted to the facility on August 29, 2013, with diagnoses including Atrial Fibrillation, Hypertension, Chronic Obstructive Pulmonary Disease, Deep Vein Thrombosis, Osteoarthritis, and Left Femur and Patella Fractures. Medical record review of admission orders dated August 29, 2013, revealed the resident was receiving Lovenox (anticoagulant) 40 mg (milligrams) subcutaneous daily and Coumadin (anticoagulant) 5 mg each evening. Medical record review of the care plan dated August 29, 2013, revealed no documentation of potential for bleeding due to anticoagulant therapy as a resident need nor was there documentation of frequency of laboratory studies, monitoring for signs/symptoms of bleeding, and	F 279	F279 (con't) problems have care plan in place addressing interventions to prevent/de-escalate. 3 nursing associates, consisting of RNs, LPNs, or, other designee will check care plans daily for residents on Coumadin medication to ensure care plan addresses monitoring for signs/symptoms of potential bleeding. Unit Managers/Coordinators or designee will ensure meeting is taking place daily. Unit Managers/Coordinators will report the results of the daily Coumadin audits for maintaining signs and symptoms of bleeding and lab work to the morning leadership meeting daily Monday through Friday. The Director of Nursing will report results to the Performance Improvement Committee until 3 continuous months of 100% compliance and report any discrepancies to Performance Improvement Committee, consisting of Interdisciplinary Team made up of the Medical Director, Director of Nursing, Executive Director, and other department heads including Social Services Director, Staff Development Coordinator, Executive Chef, Dietician, Recreation Services Director, Director of Rehab, Health Information Management Director, for further recommendations if needed.	2/4/14

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F 279	Continued From page 6 safety measures. Interview with the Director of Nursing on January 9, 2014, at 4:40 p.m., in the conference room, confirmed the care plan did not reflect precautions/instructions for a resident receiving anticoagulant therapy. Resident #226 was admitted to the facility on September 4, 2013, with diagnoses including Hypertension, Atherosclerotic Cardiovascular Disease, Osteoarthritis, Abdominal Aortic Aneurysm, Evacuation of Subdural Hematoma, Cerebrovascular Accident, Coronary Artery Bypass Graft, and Pacemaker Insertion. Medical record review of a nursing note dated October 23, 2013, revealed, "...Pounding screen of television with a book. Also reached and pulled on television several times, then continued to smear thickened liquids from a cup all over the screen..." Medical record review of a nursing note dated November 4, 2013, revealed, "...resident had a butter knife and was striking out at staff. The resident stated people were trying to take things away from...Resident told spouse on telephone 'you need to call the police and tell them they need to come take care of things. You better listen to me or someone will be hurt.' Physician was called and ordered the resident be sent out for altered mental status and combativeness..." Review of the care plan revealed no documentation of behavior as being a problem and no interventions to prevent/de-escalate behaviors.	F 279		2/4/14

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F 279	Continued From page 7 Interview with the Administrator and Director of Nursing (DON) on January 9, 2014, at 8:45 a.m., in the Administrator's office, revealed the Administrator was called to the dining room where the resident was found with knife, fork, and spoon in hand, waving the arm around. Continued interview revealed the resident dropped the knife on the floor and the Administrator was able to pick it up. Further interview revealed the Administrator refused readmission to the resident after discharge from the psychiatric facility because the facility was unable to care for residents with behavioral issues and the Administrator felt the resident was a risk to himself, staff, and visitors. Interview with the DON confirmed the care plan did not reflect the resident's behavior issues.	F 279		2/4/14
F 280 SS=D	COMPLAINT #32761 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280	F280 Resident #170 was completed his/her rehabilitation stay and discharged home safely in November 2013. Audit conducted by Unit Manages/Coordinators and MDS Nurses to ensure residents with significant weight loss/gain have care plans that have been appropriately updated to reflect current interventions. Care Plans will be reviewed for current interventions and accuracy during weekly Nutrition Intervention Program meeting by interdisciplinary team consisting of Dietician, Therapy, Social Services, and Nursing Managers/Coordinators.	1/31/14

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F 280	Continued From page 8 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to revise the care plan to address a significant weight increase for one resident (#170) of thirty-five residents reviewed. The findings included: Resident #170 was admitted to the facility on October 4, 2013, with diagnoses including Hypertension, Esophageal Reflux, Morbidly Obesity, Arthropathy, Knee Replacement, Lymphedema, Chronic Pain, Depression, Anemia, and Atrial Fibrillation. Medical record review of the Weight History revealed the admission weight on October 4, 2013, was 250 pounds (#). Further review revealed the weight on October 14, 2013, was 255#, a five pound increase in one week. Further review revealed the weight on October 21, 2013, was 258#, an eight pound increase in the two weeks after admission. Further review revealed the weight on October 28, 2013, was 316#, a significant (significant defined as greater than 5% weight change in one month) increase of 58# in one week or 18.4%. Further review revealed the weight on November 4, 2013, was 319#, a significant increase of 69# or 21.6% in one month.	F 280	F 280 (con't) Dietician or designee will report the results of the weekly weight loss/gain intervention care plan audits to the Performance Improvement Committee until 3 continuous months of 100% compliance and report any discrepancies to Performance Improvement Committee, consisting of Interdisciplinary Team made up of the Medical Director, Director of Nursing, Executive Director, and other department heads including Social Services Director, Staff Development Coordinator, Executive Chef, Dietician, Recreation Services Director, Director of Rehab, Health Information Management Director, for further recommendations if needed.	1/31/2014

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F 280	Continued From page 9 Medical record review of the Interim Care Plan dated October 9, 2013, revealed the resident need of Nutrition/Hydration Needs - BMI (Body Mass Index) greater than 40 with the Goal to maintain present weight. Medical record review of the care plan dated October 24, 2013, revealed the resident was at "nutritional risk" with the Goal of "will sustain no significant weight loss..." Review of the facility policy entitled Weight Monitoring with the last revised date of March 1, 2013, revealed, "...Weight variances are reviewed for residents with a 5% weight change in 30 days...Any resident who experiences...a significant weight change...loss or gain...Unplanned weight gain in a resident may have significant health implications and therefore is addressed...The Interdisciplinary Care Plan Team addresses the issue of the...weight gain...reflects current interventions...." Interview on January 9, 2014, at 11:30 a.m., in the Administrator's office, with the Administrator, Director of Nursing, and the Regional Vice President, confirmed the facility failed to revise the care plan to address the significant weight gain per the facility policy.	F 280		1/31/2014
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281	F281 Resident's Medication Administration Record was corrected to reflect correct dosage. Resident #308 has since completed his/her rehabilitation stay and discharged home safely.	1/9/14

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F 281	Continued From page 10 Based on medical record review, observation, and interview, the facility failed to follow physician's orders for medication administration for one resident (#308) of thirty-five resident's reviewed. The findings included: Resident #308 was admitted on December 30, 2013, with diagnoses including Gastroenteritis, Colitis, Diabetes Mellitus, and Chronic Kidney Disease (Stage III). Medical record review of a Physician's Order dated December 30, 2013, revealed, "...D/C (discontinue) Vitamin D3 1,000 Units, Add: Vitamin D3 2,000 Units P.O. (by mouth, orally) daily..." Review of the Medication Administration Record (MAR) dated January 2014, revealed, "...Vitamin D3 1,000 units PO Daily dx (diagnosis): supplement..." Observation during the medication pass on January 9, 2014, at 9:10 a.m., on the 200 hall with Registered Nurse #1, revealed the nurse prepared Vitamin D3, 1000 Units, and administered the medication to resident #308. Interview with the Director of Nursing in the conference room on January 9, 2014, at 10:30 a.m., confirmed the physician's order had not been transcribed to the Medication Administration Record (MAR) correctly, and the resident had not received the correct dose of Vitamin D3. c/o #32761	F 281	F 281 (con't) Audit conducted by Unit Managers/Coordinators and designees of all Medication Administration Records to ensure all changes in physician orders are transcribed correctly. Initiated on 1/27/14. Unit Managers/Coordinators or designee will check physician order changes daily to ensure Medication Administration Records match the new orders. Any discrepancies will be corrected at the time checked and reported to the Director of Nursing. The DON or designee will report the results of the daily physician order checks to the Performance Improvement Committee until 3 continuous months of 100% compliance and report any discrepancies to Performance Improvement Committee, consisting of Interdisciplinary Team made up of the Medical Director, Director of Nursing, Executive Director, and other department heads including Social Services Director, Staff Development Coordinator, Executive Chef, Dietician, Recreation Services Director, Director of Rehab, Health Information Management Director, for further recommendations if needed.	1/31/14 2/14/14

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to ensure residents received adequate monitoring of medications by completing the Behavior/Intervention Monthly Flow record for two residents (#67, #270) of thirty-five residents reviewed. The findings included:	F 329	F329 Resident #67 and #270 have both completed their rehabilitation stays and discharged with no problems. Audit was conducted during psychotropic medication meeting, consisting of Social Service director, Social Services assistant, Director of Nursing, Executive Director, Rec Services Director, and Unit Managers/Coordinators to ensure appropriate Behavior/Intervention Monthly Flow Records were in place for all residents receiving psychotropic medication. RNs and LPNs, were educated by Director of Nursing's designee on importance of and how to appropriately utilize Behavior/Intervention Monthly Flow Records. Audits will be conducted monthly during the psychotropic medication meeting to ensure proper use of Behavior/Intervention Monthly Flow Records. Initiated on 1/24/14 The Social Service Director or designee will report the results of the monthly Behavior/Intervention Monthly Flow Records to the Performance Improvement Committee until 3 continuous months of 100% compliance and report any discrepancies to Performance Improvement	1/23/14 2/10/14

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F 329	Continued From page 12. Resident #67 was admitted to the facility October 18, 2013, with diagnoses including Bipolar Disorder, Amnestic Disorder, Chronic Kidney Disease, COPD, Normal Pressure Hydrocephalus, Dementia, and Muscle Weakness. Medical record review of the physician's admitting orders dated October 18, 2013, revealed the resident received Lexapro (antidepressant) 10 mg (milligrams) daily and Depakote 500 mg BID (twice a day) for Bipolar Disorder. Medical record review revealed the resident's Behavior/Intervention Monthly Flow Record had not been completed and incorporated into the resident's medical record for the months of October, November, and December 2013, and January 2014. Resident #270 was admitted to the facility on December 19, 2013, with diagnoses including Aftercare of Fracture of Upper Arm, Depressive Disorder, Hypertension, Anxiety, and Hypothyroidism. Medical record review of the physician's admitting orders dated December 19, 2013, revealed the resident received Xanax (Antianxiety) 1 mg bid and Cymbalta (Antidepressant) 30 mg daily. Medical record review revealed the resident's Behavior/Intervention Monthly Flow Record had not been completed and incorporated into the resident's medical record for the months of December 2013 and January 2014. Review of the facility policy Psychotropic	F 329	F 329 (con't) Committee, consisting of Interdisciplinary Team made up of the Medical Director, Director of Nursing, Executive Director, and other department heads including Social Services Director, Staff Development Coordinator, Executive Chef, Dietician, Recreation Services Director, Director of Rehab, Health Information Management Director, for further recommendations if needed.	

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F 329	Continued From page 13 Medication Administration Mental Health Referral Consultation revealed, "...3. Behavior Monitoring Records will be completed by each nurse administering the medication (psychotropic medication)..." Interview with the 100 hall Minimum Data Set (MDS) Coordinator on January 9, 2014, at 11:40 a.m., at the 100 hall nurse's station, confirmed the Behavior/Intervention Monthly Flow Record had not been completed per facility policy for residents #67 and #270.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of manufacturer's recommendations, the facility dietary department failed to maintain sanitary dietary equipment; failed to sanitize items in the three compartment sink for at least one minute; and failed to prevent cross contamination in the dish room. The findings included:	F 371	F371 The effected pot from the three compartment sink and the effected cross contaminated dishes were rewashed to ensure proper cleaning sanitizing compliance. The can opener, tilt skillet, and grill spill pan were cleaned to remove debris. Executive Chef educated all dietary associates on importance of leaving items in the sanitizing sink for at least one minute. Education included the importance of preventing cross contamination and importance of thorough cleaning of all equipment. Education included a demonstration of the three compartment sink and how to properly unload the dish machine. To complete education associates demonstrated proper use back to the Executive Chef. All new dietary associates will complete proper demonstration during dietary orientation.	1/9/14 1/10/14

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F 371	Continued From page 14 Observation revealed and interview confirmed, on January 8, 2014, at 3:20 p.m., with the Executive Chef, the following: 1.) The can opener slot and blade had a heavy accumulation of sticky debris. 2.) The interior left side and interior back side of the tilt skillet had dried brown smears present. 3.) The left interior side of the grill spill pan had a heavy accumulation of blackened debris present. Observation on January 8, 2014, at 3:23 p.m., in the dietary department three compartment sink room, with the Executive Chef present, revealed the three compartment sink was set-up and in use. Further observation revealed the dietary staff member washed, rinsed and then dipped the pot into and out of the sanitizer sink and placed the pot on the drainage board. Review of the posted procedure for the set-up and procedure of the three compartment sink revealed the item in the sanitizer sink was to be submerged for at least one minute. Interview on January 8, 2014, at 3:25 p.m., with the dietary staff member working at the three compartment sink, with the Executive Chef present, confirmed the pot had been dipped into and out of the sanitizer solution. Further interview revealed the dietary staff member had dipped several pot lids into and out of the sanitizer solution. Further interview with the Executive Chef confirmed the dietary staff member had failed to follow the posted requirement of submerging the items in the sanitizer solution for one minute. Observation revealed and interview confirmed, on January 9, 2014, at 9:10 a.m., in the dietary	F 371	F 371 (con't) Weekly sanitation audits will be completed by the Executive Chef, Dietician, or designee to ensure cleaning of kitchen items are completed per policies to ensure sanitary conditions beginning the week of 2/4/14. The Executive Chef, Dietician or designee will report the results of the weekly sanitation audits to the Performance Improvement Committee until 3 continuous months of 100% compliance and report any discrepancies to Performance Improvement Committee, consisting of Interdisciplinary Team made up of the Medical Director, Director of Nursing, Executive Director, and other department heads including Social Services Director, Staff Development Coordinator, Executive Chef, Dietician, Recreation Services Director, Director of Rehab, Health Information Management Director, for further recommendations if needed.	2/10/14

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F 371	Continued From page 15 department dish room, with the Executive Chef, the dish machine was in operation. Further observation revealed and interview confirmed the dietary staff member working the dish machine pushed a rack containing dirty dishes into the dish machine and the rack came in direct contact with a rack of cleaned dishes inside the dish machine in order to eject the cleaned rack of dishes in three consecutive operations. Further interview with the dietary staff member working the dish machine, confirmed the correct process was to wash hands, go to the clean side of the dish machine, open the dish machine door to remove the clean dishes, then go to dirty side of the machine and load the dirty dishes into the dish machine. Further interview with the dietary staff member revealed "I just got rushed." Further interview with the Executive Chef, present during the observation, confirmed the dietary staff member cross contaminated the clean dishes by pushing the dirty dishes in direct contact with the cleaned dishes inside the dish machine Observation revealed and interview confirmed, on January 9, 2014, at 9:20 a.m., with the Executive Chef, the left interior side of the grill spill pan had a heavy accumulation of blackened debris present.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441	F 441 Audit conducted by Director of Nursing concluded that all Healthcare-Associated Infection Summary Reports were in place from January 2013 through present.	2/10/14

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F 441	Continued From page 16 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on facility documentation, facility policy review, and interview, the facility failed to monitor residents presenting with gastrointestinal symptoms for determining severity and scope of the illness. The findings included:	F 441	F 441 (con't) RN and LPNs, were educated on the importance of and how to report signs and symptoms of infection to the physician as well as to a Unit Coordinator/Manager or Director of Nursing in order to detect, prevent, and control infections among residents and personnel in accordance with facility protocol. Initiated on 1/28/14. The Staff Development Coordinator or designee will bring the monthly Healthcare-Associated Infection Summary Report to the Performance Improvement Committee, consisting of Interdisciplinary Team made up of the Medical Director, Director of Nursing, Executive Director, and other department heads including Social Services Director, Staff Development Coordinator, Executive Chef, Dietician, Recreation Services Director, Director of Rehab, Health Information Management Director, for further recommendations if needed.	2/10/14

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F 441	Continued From page 17 Review of the nursing documentation from the 24 hour alert charting logs for the month of December 2012, with the Director of Nurses on January 9, 2014, at 3:00 p.m., in the library, revealed fifteen residents had exhibited symptoms of nausea, vomiting, and/or diarrhea throughout the month. Review of the facility's documentation, Healthcare-Associated Infection Summary Report by Resident Days (a compilation of infectious processes monitored monthly), dated December 2012, revealed no documentation the residents with gastrointestinal (GI) symptoms (nausea, vomiting, diarrhea) had been monitored during the month of December 2012. Review of the facility's policy, Scope of the Infection Control Program, revealed, "The organization-wide infection control program is comprehensive in that it addresses detection, prevention, and control of infections among residents and personnel...Goals of the Infection Control Program, Reduce the risk of acquisition and transmission of healthcare-associated infections. Monitor for any occurrences of infection and implement appropriate control measures. Identify and correct problems relating to infection control practices..." Interview with the Director of Nursing on January 9, 2014, at 3:00 p.m., in the library, confirmed that due to the number of multiple cases of residents with GI symptoms, these residents should have been included in the infection control monitoring. C/O #31500	F 441		

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F 514	Continued From page 18	F 514		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to document pain assessments for one resident (#279) for the effectiveness of pain management of thirty-five residents reviewed. The findings included: Resident #279 was admitted to the facility on December 27, 2013, with diagnoses including Intertrochanteric Femur Fracture (hip fracture), Cardiomyopathies, Chronic Kidney Disease (Stage IV), Hypertension, and Diabetes Mellitus. Medical record review of the Physician's Orders dated December 2013, revealed, "...Pain assessment Q (every) shift document pain scale 0-10...Norco (narcotic analgesic for pain relief) 5 mg (milligrams) - 325 mg tablet 1 tablet every 4	F 514	F 514 Resident #279 was discharged from facility in January. An audit was conducted by nursing administration consisting of Director of Nursing, Unit Managers/Coordinators of other residents' pain flow sheets for residents who have orders for prn pain meds to ensure compliance. RNs and LPNs were in-serviced and re-educated on proper use of the pain flow sheets and when the sheets should be initiated and documented. Initiated on 1/24/14 The Director of Nursing or designee will conduct weekly audits of pain flow sheets to ensure usage for residents receiving prn pain meds. Nurses not found to be not documenting pain flow sheets correctly will be subject to corrective action. The Director of Nursing or designee will report the results of the pain flow sheet audits to the Performance Improvement Committee until 3 continuous months of 100% compliance and report any discrepancies to Performance Improvement Committee, consisting of Interdisciplinary Team made up of the Medical Director, Director of Nursing, Executive Director, and other department heads including	1/31/14 2/10/2014

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F 514	Continued From page 19 hours x (times) 14 days po (by mouth) prn (as needed) dx (diagnosis): pain management..." Review of the Care Plan dated December 27, 2013, revealed the need for pain management. Continued review of the Care Plan revealed the following interventions: 1) Educate resident on pain management program; 2) Monitor pain intensity following medication or treatment; 3) Observe for behaviors that may indicate pain or increased pain, verbal, non-verbal; 4) Reassess pain management efficacy and as needed. Review of the Medication Administration Record for January 2014, revealed the resident had received multiple doses of PRN pain medication daily from January 1 through January 9, 2014. Review of the Pain Flow Sheet dated January 2014, revealed three completed entries for the month, twice on the 5th and once on the 8th of January 2014. Observation of the resident in the resident's room on January 10, 2014, at 7:45 a.m., revealed the resident ambulated from the bathroom to the wheelchair with a rolling walker, making slow and deliberate movements. Continued observation revealed the resident ambulated unassisted with the walker to the wheelchair, turned and lowered self into the wheelchair. Interview on January 10, 2014, at 7:55 a.m., with the Director of Nursing at the 200 hall nurse's station, confirmed documentation was to be completed on the Pain Flow Sheet each time the resident received PRN pain medication to provide accurate assessment of pain management. Continued interview confirmed the Pain Flow	F 514	F514 (con't) Social Services Director, Staff Development Coordinator, Executive Chef, Dietician, Recreation Services Director, Director of Rehab, Health Information Management Director, for further recommendations if needed.	

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F 514	Continued From page 20 Sheet had not been completed for the PRN medication administered to the resident.	F 514		2/10/14